

MITT ROMNEY  
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KERRY HEALEY  
LIEUTENANT GOVERNOR

RONALD PRESTON  
SECRETARY

CHRISTINE C. FERGUSON  
COMMISSIONER

The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health  
Radiation Control Program  
90 Washington Street, Dorchester, MA 02121  
(617) 427-2944 (617) 427-2925 - Fax

POTENTIAL MASSACHUSETTS RADIOLOGIC TECHNOLOGIST LICENSEE:

Chapter 111, Section 5L of the Massachusetts General Laws established an Advisory Commission for licensing radiologic technologists within the Commonwealth. This statute mandates that no person shall perform the duties of a radiologic technologist (x-ray, nuclear medicine or radiation therapy technologist) without such license and further that the fee for such license and renewal shall be determined annually by the Commissioner of Administration.

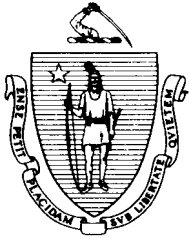
The Advisory Commission for Radiologic Technologists was established under this statute and developed regulations which were effective March 1, 1988 (116 CMR 2.00). Under these regulations, Section 2.03 states that an individual who is a certified radiologic technologist in a national or international certifying board, shall be deemed licensed provided such board is recognized by the Commission. You should complete this application only if you have successfully passed a qualifying examination given by one of the following certification boards:

American Registry of Radiologic Technologists  
British College of Radiographers  
Australian Institute of Radiography  
Canadian Association of Medical Radiologic Technologists  
Nuclear Medicine Technologists Certification Board  
Massachusetts Civil Service Exam

**Once you have completed the enclosed application, return it with a notarized copy of your certification card and a \$75.00 application/processing fee. Please make your check payable to the Commonwealth of Massachusetts and mail it in the enclosed envelope.**

When you return your completed application along with the fee, we will review your documents for eligibility and if everything is correct, we will then issue you an invoice for your actual license. Upon your prompt payment of this invoice, we will then issue you a Massachusetts Radiologic Technologist License.

If you have any further questions concerning the application process, please contact this office during normal business hours.



Commonwealth of Massachusetts Radiologic Technologist Licensing  
Application Form

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS (mailing) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRESENT EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

LICENSING CATEGORY (check appropriate one)

- |   |       |
|---|-------|
| 1. General Radiography Technology               | _____ |
| 2. Limited Radiography Technology - Chest       | _____ |
| 3. Limited Radiography Technology - Extremities | _____ |
| 4. Limited Nuclear Medicine Technology          | _____ |
| 5. Nuclear Medicine Technology                  | _____ |
| 6. Radiation Therapy Technology                 | _____ |

YEAR OF QUALIFYING EXAMINATION\*

Examining Body	Certification Number(s)	Active/Inactive Status

\*QUALIFYING EXAMINATIONS ARE AS FOLLOWS:

American Registry of Radiologic Technologists  
British College of Radiographers  
Australian Institute of Radiography  
Canadian Association of Medical Radiologic Technologists  
Nuclear Medicine Technologists Certification Board  
Massachusetts Civil Service Exam  
American Society of Clinical Pathologists  
Massachusetts Civil Service Exam  
Massachusetts Radiologic Technologist Licensing Exam

NOTE: First time application only - attach a notarized copy of above certification

RADIOLOGIC TECHNOLOGIST EMPLOYMENT HISTORY FOR THE PAST FIVE YEARS  
(Use additional paper if necessary)

EMPLOYER (most recent first)

DATES OF EMPLOYMENT

1.Name: \_\_\_\_\_

\_\_\_\_\_ to \_\_\_\_\_

address: \_\_\_\_\_

telephone number: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supervisor: \_\_\_\_\_

\_\_\_\_\_

EMPLOYER

DATES OF EMPLOYMENT

2.Name: \_\_\_\_\_

\_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supervisor: \_\_\_\_\_

\_\_\_\_\_

EMPLOYER

DATES OF EMPLOYMENT

3.Name: \_\_\_\_\_

\_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supervisor: \_\_\_\_\_

\_\_\_\_\_

EMPLOYER

DATES OF EMPLOYMENT

4.Name: \_\_\_\_\_

\_\_\_\_\_ to \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supervisor: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HAVE YOU EVER (a) BEEN CONVICTED OF A FELONY, (b) BEEN FOUND TO HAVE COMMITTED MALPRACTICE, OR (c) PAID, OR HAVE HAD PAID ON YOUR BEHALF, ANY AMOUNT OF MONEY TO SETTLE A MALPRACTICE SUIT?

IF YES, PLEASE EXPLAIN \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE OF HIGH SCHOOL GRADUATION OR EQUIVALENT \_\_\_\_\_

LIST ALL QUALIFYING PROFESSIONAL EDUCATION

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CHECK OTHER RADIOLOGIC TECHNOLOGY CATEGORY LICENSES HELD IN-STATE  
[check appropriate one(s)]

- |    |                                     |       |
|----|-------------------------------------|-------|
| 1. | General Radiography                 | _____ |
| 2. | Limited Radiography - Chest         | _____ |
| 3. | Limited Radiography - Extremities   | _____ |
| 4. | Limited Nuclear Medicine Technology | _____ |
| 5. | Nuclear Medicine Technology         | _____ |
| 6. | Radiation Therapy                   | _____ |

HAS YOUR LICENSE/CERTIFICATION EVER BEEN REVOKED BY ANY STATE OR  
CERTIFYING BOARD? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, PLEASE EXPLAIN

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NOTE: If extra space is needed for any answers on this application form, please use additional sheets of paper so all questions are answered fully. Attach additional sheets to the back of the application

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND COMPLETE

SIGNED UNDER THE PENALTIES OF PERJURY:

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE